2001 Open Enrollment for 2002

Deputy Sheriff COBRA or Retiree Benefits Participant with Dental Only

This guide explains your dental benefit and the changes you can make to your coverage during this open enrollment. The guide includes a Resource Directory listing whom to contact if you have any questions (page 3), plus the forms you need to make changes (pages 5-8).

During open enrollment you may:

- Drop dental coverage
- Add new eligible family members for coverage
- Drop currently covered family members from coverage.

Please review the guide and if you decide to make changes, return the forms **by Friday, November 30** to:

Associated Administrators, Inc.
PO Box 3988
Portland OR 97208-3988

If you decide to keep the same coverage in 2002, do nothing -- simply keep all materials for reference.

This guide is not a complete description of each plan. More details about each benefit are in your plan booklets, available at www.metrokc.gov/ ohrm/ benefits or in alternate formats from Benefits & Well-Being. Although we've made every effort to ensure this guide is accurate, provisions of the official plan documents and contracts will govern in the case of any discrepancy. As explained in the plan booklets, the benefit program is subject to review and may be modified or terminated at any time for any reason. This guide does not create a contract of employment between King County and any former employee.

King County Office of Human Resources Management
BENEFITS & WELL-BEING

■ Dental

Your dental coverage is provided through Washington Dental Service (WDS). In 2002, there are no changes to dental coverage but cost for the coverage increases.

WDS increases your payment levels through its incentive program when you regularly see your dentist. For diagnostic and preventive services as well as basic and restorative services the payment level starts at 70% and increases 10% for each calendar year until you reach 100% (as long as you visit your dentist each year). If you do not see the dentist during the calendar year your payment level is reduced to the next lower payment level, but never below 70%.

Washington Dental Service	
Annual deductible	None, but you and each covered family member pay coinsurance (if any), amounts in excess of usual and customary rates (unless you see a participating dentist) and expenses for services not covered.
Annual max benefit (doesn't apply to orthodontic or TMJ services)	$2,500/person
Covered Expenses	**Plan Pays**
Diagnostic and preventive services (1 exam and cleaning every 6 months, complete x-rays every 3 years, supplemental bitewing x-rays every 6 months)	70% - 100% based on your incentive level; see dental booklet for details
Basic services (fillings, stainless steel crowns, extractions, root canals, periodontics)	70% - 100% based on your incentive level; see dental booklet for details
Major services – restorative (crowns, onlays, fixed bridges)	70% - 100% based on your incentive level; see dental booklet for details
Major services – prosthodontics (dentures)	70%
Orthodontic services (for adults and children)	60%, up to a $2,500 lifetime benefit max
Orthognathic surgery	70% up to a $5,000 lifetime benefit max
Accidental injury	100%

■ Cost

Monthly rates for COBRA and retiree rates are based on what King County pays to provide the same coverage for active employees. The following table lists 2001 and 2002 rates. The rate for dependent children applies whether you cover one child or several, as long as you or your spouse also elects self-paid coverage. Add across the row for the family members you cover for your total monthly cost.

		You	Spouse/DP*	Dependent Child(ren)	Your Total Monthly Cost
Washington Dental Service	*2001*	$ 50.68	$ 50.68	$ 40.55	
	2002	$ 56.76	$ 56.76	$ 45.41	

■ Adding and Deleting Family Members

Do you want to keep the same eligible family members covered under your benefit plans? Do you want to add or drop family members?

The following family members are eligible under your coverage if you enroll them:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership required if not previously submitted; page 11)
- Unmarried children of you or your spouse/domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally, that means you claim them on your federal tax return). A child may be your natural child, adopted child, stepchild, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.
  - Named in a Qualified Medical Child Support Order as defined under federal law and authorized by the plan.

To add family members not previously covered, list them on your open enrollment form and provide all information indicated. Include additional documentation as required (Affidavit of Marriage/Domestic Partnership, QMCSO, etc.).

To delete family members from coverage, complete the delete sections on the back of your open enrollment form and provide all information indicated for each deleted family member. This ensures COBRA information is sent to your deleted family members, as required by law. If you delete a spouse/domestic partner from coverage, complete a Termination of Marriage/Domestic Partnership Statement (page 12).

■ Resource Directory

Questions About …	Contact ...
General Benefits	**Benefits & Well-Being** Yesler Building YES-HR-0500 400 Yesler Way, Seattle WA 98104-2683 Phone 206.684.1556* ▪ 1.800.325.6165 x41556* ▪ Fax 206.684.1925 kc.benefits@metrokc.gov ▪ www.metrokc.gov/ohrm/benefits
COBRA and Retiree Benefits Administration • Completing forms • Premium payments	**Associated Administrators Incorporated** PO Box 3988, Portland OR 97208-3988 Phone 1.800.320.2915* ▪ Fax 503.727.7444 aaicobra@aai-tpa.com
Dental • Providers • Filing claims • Other plan details	**Washington Dental Service** PO Box 75688, Seattle WA 98125-0688 Phone 1.800.554.1907* ▪ 206.522.2300* cservice@deltadentalwa.com ▪ www.deltadentalwa.com

* TTY 1.800.833.6388 (Washington Relay Service)

King County Deputy Sheriff COBRA or Retiree Benefits Open Enrollment Form
Dental Only

If you wish to change coverage, please return forms **by Friday, November 30**
to Associated Administrators Inc., PO Box 3988, Portland OR 97208-3988.
No changes? Do nothing -- simply keep all materials for reference.

■ Plan Participant

_____ _____
First Name MI Last Name Birth Date

_____ (_____)_____
Social Security Number Area Code Phone

Billing Address _____
Street Apt No City State ZIP

Home Address _____
Street Apt No City State ZIP

■ Covered Family Members

List eligible family members for coverage. Check the box if they're new and attach Affidavit of Marriage/DPship if applicable. Complete back of form if you delete any family members previously covered and attach Termination of Marriage/DPship Statement if applicable.

New	Name	Relationship	Social Security Number	Birth Date	Gender
☐					
☐					
☐					
☐					
☐					
☐					

■ Coverage Options

Check one: ☐ Continue dental coverage ☐ Drop dental coverage

■ Authorization

This form supersedes all other forms. I have read and understand it and open enrollment materials describing my options. The information I provided is true, correct and complete. I hereby certify I remain eligible for COBRA or retiree benefits coverage -- I have not become covered under another group plan. I authorize the insurance carriers to coordinate benefits and process claims for my family and me. I understand the elections I made are binding and cannot be revoked or modified except as explained in the materials provided and until I submit a new form.

Signature _____ **Date Signed** _____

■ **Delete** ☐ Spouse ☐ Natural child ☐ Adopted child ☐ Child placed under guardianship
☐ Domestic partner ☐ DP's child ☐ Foster child ☐ Disabled adult child

Gender ☐ Male ☐ Female

Qualifying Event ☐ Death ☐ Child turned 23
☐ Divorce/dissolution of domestic partnership -- attach statement ☐ Child no longer dependent
☐ End of qualified medical child support order -- attach copy ☐ I opt not to pay for coverage

Event Date ________________________

Address required for COBRA notification if deleted person living.

Name ____

Soc Sec No ______________________ Birth Date ______________________

Street ______________________________ Apt No ______________

City ______________________ State ________ ZIP ______________

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Event Date ________________________

Address required for COBRA notification if deleted person living.

Name ____

Soc Sec No ______________________ Birth Date ______________________

Street ______________________________ Apt No ______________

City ______________________ State ________ ZIP ______________

Affidavit of Marriage/Domestic Partnership

Submit this form with your open enrollment form to document a new marriage or domestic partnership.

■ **Check all boxes that apply**

☐ Add my spouse or domestic partner (DP) for benefit coverage.

☐ This form documents my marriage or domestic partnership, but do not add my spouse or DP for benefit coverage at this time.

■ **Check one of the following boxes and provide date**

☐ I (employee) certify my spouse (named below) and I legally married (date) _____.

☐ I (employee) certify my DP (named below) and I began our domestic partnership (date) _____ and we:

- Share the same regular and permanent residence
- Have a close personal relationship
- Are jointly responsible for *basic living expenses**
- Are not married to anyone
- Are both 18 years of age or older
- Are not related by blood closer than would bar marriage in the State of Washington
- Were mentally competent to consent to contract when our domestic partnership began, and
- Are each other's sole domestic partners and are responsible for each other's common welfare.

* *Basic living expenses means the cost of basic food, shelter and any other expenses of a DP paid at least in part by a program or benefit for which the partner qualified because of the DPship. The individuals need not contribute equally or jointly to the cost of these expenses as long as they both agree they are responsible for the cost.*

■ **Authorization**

I understand this affidavit will no longer be effective if my spouse/DP dies or if there is a change of circumstances attested to in this affidavit.

I agree to notify AAI if there is any change of circumstances attested to in this affidavit within 60 days of such change by filing a Statement of Termination of Marriage/Domestic Partnership.

We understand this information will be held confidential and subject to disclosure only upon express written authorization or if otherwise required by law.

We understand this declaration of responsibility for our common welfare may have legal implications under Washington State law.

We understand a civil action may be brought against us for any losses, including reasonable attorney fees, because of a false statement contained in this Affidavit of Marriage/Domestic Partnership.

We certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Participant Signature_____ **Date Signed** _____

Soc Sec No _____

Spouse/DP Signature _____ **Date Signed** _____

Spouse/DP Printed Name _____

Termination of Marriage/Domestic Partnership Statement

Submit this form with your open enrollment form to document a divorce or end of a domestic partnership.

■ **Check one of the following boxes**

☐ The termination is due to the dissolution of our marriage Date: _____

☐ The termination is due to the termination of our domestic partnership Date: _____

☐ The termination is due to the death of my spouse/domestic partner Date: _____

■ **COBRA notification address**

Provide the address of the deleted spouse/domestic partner (if living) so COBRA information can be mailed as required by law.

Spouse/DP Printed Name _____

Spouse/DP Soc Sec No _____

Address _____

_____

■ **Authorization**

I (participant) affirm the affidavit of marriage/domestic partnership attested to and signed by me with my former spouse/domestic partner is terminated as of the date indicated above. I understand I must submit this statement of termination to AAI and mail a signed copy to my surviving former spouse/domestic partner within 60 days of the termination or my former spouse/domestic partner will not be given COBRA election rights. I certify under penalty of perjury, under the laws of the State of Washington, the foregoing is true and correct.

Participant Signature _____ **Date Signed** _____

Soc Sec No _____